Medco By Mail ORDER FORM

UnitedHealthcare®
A UnitedHealth Group Company

1 Customer information: Please verify or provide customer information below.

Subscriber #: _____

Rx Grp #: UHEALTH

Name: _____

Street Address: _____

Street Address: _____

Street Address: _____

City, ST, ZIP: _____

Daytime phone: ☐☐☐ ☐☐☐ ☐☐☐☐

☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:
_____@_____.____

☐ New shipping address:

_____

_____

_____

(Medco will keep this address on file for all orders from this subscriber until another shipping address is provided by any person in this plan.)

Evening phone: ☐☐☐ ☐☐☐ ☐☐☐☐

FOLD HERE

2 Patient/doctor information: Complete **one section** for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in one envelope.

First name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Birth date (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐

Sex ☐ M ☐ F

Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

1st initial ☐

Doctor's phone number ☐☐☐ ☐☐☐ ☐☐☐☐

First name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Birth date (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐

Sex ☐ M ☐ F

Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

1st initial ☐

Doctor's phone number ☐☐☐ ☐☐☐ ☐☐☐☐

FOLD HERE

3 Complete your order: You can pay by e-check, check, money order, or credit card. Make checks and money orders **payable to MedcoHealth Solutions, Inc.**, and write your subscriber ID number on the front. You can enroll for e-check payments and price medications at **www.myuhc.com** or call **1 800 948-8779.**

Number of prescriptions sent with this order: ☐

Payment options: ☐ e-check ☐ Payment enclosed ☐ Credit card ☐ Send bill

For credit card payments:
☐ Visa ☐ MC ☐ Discover ☐ AmEx ☐ Diners

Credit card number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration date ☐☐ ☐☐
M M Y Y

X _____
Cardholder signature

☐ I authorize Medco to charge this card for all orders from any person in this plan.

☐ Rush the mailing of this shipment ($14, cost subject to change). NOTE: This will only rush the shipping, not the processing of your order. Street address is required; P.O. box is not allowed.

Mailing instructions are provided on the back of this form.

Patient/doctor information continued

First name | Last name

Birth date (MM/DD/YYYY) | Sex ☐ M ☐ F | Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name | 1st initial | Doctor's phone number

First name | Last name

Birth date (MM/DD/YYYY) | Sex ☐ M ☐ F | Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name | 1st initial | Doctor's phone number

FOLD HERE

Important reminders and other information

Ask your doctor to write your prescription for a 90-day supply with refills when appropriate. You will be charged a mail order co-payment regardless of the days' supply written on the prescription. Please be sure that your doctor writes your prescription for a 90-day supply, not a 30-day supply with 3 refills.

Complete the Health, Allergy & Medication Questionnaire.

There may be a limit to the balance that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

If you are a Medicare Part B beneficiary AND have private health insurance, check your pharmacy benefit materials to determine the best way to get Medicare Part B medications and supplies. Or, call the Customer Care number on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1 800 MEDICARE (1 800 633-4227).

Automatic generic equivalent substitution of certain brand-name medications is allowed by law in Texas, Florida, and Ohio, unless you or your doctor specifically directs otherwise.

☐ If you live in Texas, you have a right to refuse safe, effective generics. Check the box **if you do not want** the generic medication. This applies only to the prescription medication(s) on this order.

☐ Pennsylvania law permits pharmacists to substitute a less expensive generically equivalent medication for a brand name medication unless you or your doctor direct otherwise. **Check the box if you do not wish a less expensive brand or generic medication "product."** Please note that this applies only to new prescriptions and to any future refills of that prescription.

For additional information or help, visit us at **www.myuhc.com** or call the Customer Care number on your ID card. TTY/TDD users should call 1 800 759-1089.

FOLD HERE

Mailing instructions: Place your prescription(s), this form, and your payment in an envelope addressed to:

MEDCO HEALTH SOLUTIONS OF FAIRFIELD
P.O. BOX 747000
CINCINNATI OH 45274-7000

Health, Allergy & Medication Questionnaire

UnitedHealthcare®
A UnitedHealth Group Company

medco®

Your privacy is important to us. We comply with federal privacy regulations. Your answers to the following questions will help us provide your pharmacy benefit services including, for example, filling prescriptions and alerting your doctor about possible medication problems. To best serve you, we need to know if you have any known allergies, conditions or diseases.

- Please complete the questionnaire for each family member enrolled in your pharmacy benefit plan.
- If you need additional forms you may call your Customer Care representative at the toll-free number listed on your ID card.
- **Return this questionnaire with your prescription or refill order form.**

SECTION 1 — **SUBSCRIBER IDENTIFICATION AND CONTACT**

UHEALTH
Group Number

Subscriber Number

Daytime Telephone Number ( ) - -

Primary Subscriber: First Name **M.I.** **Last Name**

Street Address/Apt. No. **City** **State** **Zip**

SECTION 2 — **DRUG ALLERGY CONDITIONS**

For each family member enrolled in the program, include his/her name, date of birth and gender. For each family member fill in the circle **ONLY** if an allergy or bad reaction happened anytime in the past. If you are allergic to a medication that is not listed, please print the name of the medication allergy in the bottom section of this chart.

Correct way to mark circles: ◉ Please use blue or black ink.

	Enrollee	**Spouse**	**Dependent**	**Dependent**	**Dependent**
First Name: Add last name if different than enrollee					
Date of Birth:	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Gender:	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F
Penicillins/cephalosporins (e.g. ampicillin, Keflex®)	○	○	○	○	○
Tetracycline antibiotics	○	○	○	○	○
Erythromycin, Biaxin®, Zithromax®	○	○	○	○	○
Codeine (e.g. Tylenol #3®)	○	○	○	○	○
Non-steroidal anti-inflammatory drugs (NSAIDs) (e.g. ibuprofen)	○	○	○	○	○
Aspirin (salicylates)	○	○	○	○	○
Sulfa medications	○	○	○	○	○
Iodine	○	○	○	○	○
Print other medication allergies not listed above in the space provided. Example: *morphine*					

Continue on the other side to tell us about any medical conditions. ☞

SECTION 3 **MEDICAL CONDITIONS**

Please list in the appropriate column the names of each family member enrolled. Then, for each family member, fill in the circle next to each condition if a doctor ever said ***that particular family member*** has the condition.

First Name:	Enrollee	Spouse	Dependent	Dependent	Dependent
Congestive heart failure	○	○	○	○	○
High blood pressure	○	○	○	○	○
Heart attack or angina	○	○	○	○	○
High cholesterol	○	○	○	○	○
Stroke	○	○	○	○	○
Chronic bronchitis or emphysema	○	○	○	○	○
Asthma	○	○	○	○	○
Allergies, runny nose, hay fever	○	○	○	○	○
High blood sugar (diabetes)	○	○	○	○	○
Thyroid disease	○	○	○	○	○
Peptic, stomach, or duodenal ulcer	○	○	○	○	○
Gastric reflux, heartburn, or esophagitis (GERD)	○	○	○	○	○
Inflammatory bowel disease (colitis, Crohn's disease)	○	○	○	○	○
High pressure in the eyes (glaucoma)	○	○	○	○	○
Seizures	○	○	○	○	○
Poor circulation in the legs	○	○	○	○	○
Trouble with blood not clotting properly	○	○	○	○	○
Enlarged prostate (benign prostatic hyperplasia, BPH)	○	○	○	○	○
Arthritis	○	○	○	○	○
Osteoporosis	○	○	○	○	○
Depression	○	○	○	○	○
Migraine headache	○	○	○	○	○
Print other medical conditions not listed above in the space provided. Example: *glaucoma*					

Did you complete both sides?

Please return the questionnaire with your prescription or refill order form.

Thank You